(3) the date when the provisions of the material policy or collective bargaining agreement of the Retiree's or Early Retiree's Participating Employer terminates his or their eligibility to participate.

Note: It is intended that the provisions regarding enrollment shall comply with the Health Insurance Portability and Accountability Act (HIPAA) and the applicable regulations thereto, as amended from time to time. This Plan shall be construed to comply with applicable portions of HIPAA.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will also be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) Elective **abortion**.

(2) **Acupuncture services.** in accordance with the criteria described as follows:
- a) all conventional treatment must first be tried
- b) the patient's primary physician must recommend acupuncture treatment
- c) the acupuncture must be performed by an M.D.

(3) Local Medically Necessary professional land or helicopter **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(4) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(5) **Birthing Center.** Services of a licensed birthing center in a State where such centers are recognized and accepted by proper licensing authorities.

(6) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(7) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(8) **Chiropractic Services/Spinal Manipulations services** by a licensed M.D., D.O., or D.C. subject to limitations described in the schedule of benefits.

(9) Initial **contact lenses** or glasses required following cataract surgery.

(10) **Diabetic supplies.** Medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29, subject to general provisions of the health benefit plan.

(11) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(12) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(13) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(14) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

MEDICAL BENEFITS (cont'd)

Room charges made by a Hospital are reimbursable up to the hospital's semi-private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(15) **Injectable contraceptives.** Expenses incurred for injectable contraceptives including Depo Provera.

(16) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome**, subject to the Lifetime maximum as described in the schedule of benefits.

(17) **LabOne Services.** The Plan will pay 100% of all covered charges and no deductible or copayment will be due from the covered individual for covered services received from a LabOne facility. Call 1-(800) 646- 7787 for Customer Service.

Outpatient lab work includes:

Blood Testing (e.g, cholesterol, CBC)

Urine Testing (e.g, urinalysis)

Cytology and pathology (e.g. pap smears, biopsy)

Cultures (e.g. throat culture)

Excludes:

Lab work ordered during hospitalization

Lab work needed on an emergency STAT basis

Non-laboratory work such as mammography, x-ray, imaging and dental work

Time sensitive testing such as fertility testing, bone marrow studies and spinal fluid tests

Lab work performed by another lab

Any test not covered by the Plan

Handling fees

(18) **Laboratory Services.**

(19) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(20) Services of a **midwife** if the person performing the delivery and the facility where the delivery is performed is recognized by state and properly licensed at the time delivery is performed

(21) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.
Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(22) **Norplant System.** Expenses incurred in connection with the Norplant System (levonorgestrel implants) and the insertion thereof. Removal of the implant will not be considered a Covered Expense only in those situations where the physician has determined that the useful life of the device has concluded.

(23) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(24) **Organ/tissue transplants** are only covered if the recipient is a Covered Person under the Plan. The expenses of the person who donates the organ or tissue to the covered recipient are covered, even if he is not a Covered Person.

Eligible charges incurred at a facility contracted with the Organ Transplant Network used by the Trust are paid at 100%, subject to the limits listed below. Eligible charges NOT incurred at a facility contracted with the Organ Transplant Network used by the Trust are subject to a $2,500 per admission deductible; 90% coinsurance up to a maximum of $50,000; then 100% coinsurance for remaining balance and subject to limits below.

Benefits for donor procurement are paid at 100% (subject to the deductible) up to $10,000. Covered services include the evaluation, surgical removal, storage costs and transportation of the donor organ or tissue. If the scheduled transplant is canceled due to the Covered Person's medical condition or death, and the organ/tissue cannot be transplanted into another person, benefits will still be paid.

Expenses for travel, lodging and meals for the recipient and one (1) other person are payable at 100% (subject to the deductible) up to $10,000.

The following are organ/tissue transplant procedures that are covered by the Plan. No other organ or tissue transplants are covered.

Cornea transplants

Artery or vein transplants

Kidney transplants

Joint replacements

Heart valve replacements

Implantable prosthetic lenses in connection with cataracts

Prosthetic bypass or replacement vessels

Human heart transplants

Human heart/lung transplants

Human liver transplants

Allogenic Bone marrow transplants

Autologous bone marrow transplants

Human kidney/pancreas transplants

Human lung transplants

Cord Blood Stem Cell Transplant

(25) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the **body as a result of a disabling congenital condition or an Injury or Sickness.**

(26) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(27) **Physician Care.** The professional services of a Physician for surgical or medical services.

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and

Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(28) Coverage of **Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(29) Hospital **pre-surgical Tests**

(30) **Prescription Drugs (as defined).**

(31) **Prosthetic devices** and their replacement if necessary, due to the patient's growth, normal wear and tear, or a change in the patient's condition. This includes wigs, following serious medical cause of hair loss, and 2 post mastectomy bras per year.

(32) **Reconstructive Surgery.** In accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), benefits are provided for breast reconstruction services following a mastectomy, should you choose to receive such treatment. Coverage must be determined in consultation with your attending physician and may include:

i. reconstruction of the breast on which the mastectomy was performed;

ii. reconstruction of the other breast to achieve symmetry; and

iii. prostheses and physical complications of all stages of mastectomy including but not limited to lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(33) **Routine physical examinations,** including Prostate Specific Antigen Tests, for all Covered Persons, limited to a maximum payment of $350 per calendar year, payable at 100%. This includes the exam and corresponding tests that are performed in conjunction with an annual physical, except for routine pap smears, mammograms and colorectal cancer testing, exams and lab tests as indicated below.

Routine care is care by a physician that is not for an injury or illness.

(34) **One (1) routine pap smear** per calendar year, including gynecological exam, payable at 100%. PPO and Non-PPO aggregate to the one per calendar year maximum.

(35) **One (1) routine mammogram** per calendar year, including the physical examination, payable at 100% for any covered person age 40 and over or as indicated by the American Cancer Guidelines. PPO and Non-PPO aggregate to the one per calendar year maximum.

(36) **Routine colorectal cancer testing**, exams and lab tests are a covered expense for plan members who are listed below, payable at 100%. All types of tests and the frequency of those tests are limited to those that meet American Cancer Society guidelines. Contact the Plan Supervisor for those guidelines.

(a) At least 50 years old; or

(b) Less than 50 years old and considered a high risk for colorectal cancer as indicated in the current American Cancer Society guidelines.

(37) **Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(38) **Smoking Cessation** programs are limited to one (1) three (3) month course of treatment per lifetime.

(39) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either:

(a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;

(b) an Injury; or

(c) a Sickness that is other than a learning or Mental Disorder.

(40) **Sterilization** procedures (elective) but not their reversal.

(41) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(42) The Plan will cover expenses for **training and education** rendered by a medical professional for a Covered Person or a non-Covered Person for the purpose of learning how to provide care for a Covered Person for a condition that is covered by the Plan, provided the Plan will potentially incur lowered costs for the Covered Person receiving the care as a result of such training and/or education. Examples of covered training services:

(i) The training of a diabetic to self-administer insulin and to self-test blood sugar levels, which will result in fewer visits to the Physician's office.

(ii) The training of a relative to care for a Covered Person at home which will result in avoiding the expense of private duty nursing or continued hospitalization.

Not included are self-training books or materials or other training or education not provided in person by a medical professional. The Plan Administrator shall determine if coverage shall apply to any training or education expenses.

(43) **Vision Therapy.** Vision therapy as is determined medically necessary by the Plan.

(44) **Well Newborn Routine Nursery/Physician Care**. Hospital, physician and circumcision expenses of a well newborn during confinement immediately following birth. The pre-existing condition exclusion does not apply to these services. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

(45) **Charges for Routine Well Baby Care.** Charges for well child care expenses including routine check-ups based on the limits shown in the schedule of benefits. Immunizations are covered through the age of 2, and as required thereafter by the Indiana State Board of Health based on limits shown in the schedule of benefits.

(46) Diagnostic **x-rays**.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Bereavement counseling.** Charges for bereavement counseling.

(2) **Cosmetic.** For or in connection with **cosmetic treatment** unless due to an injury resulting in damage to his person requiring the cosmetic treatment;

(3) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(4) **Dental.** Treatment of teeth or gums except as the result of an accidental Injury to natural teeth occurring while covered.

(5) **Educational or vocational testing.** Services for educational or vocational testing or training.

(6) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(7) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(8) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(9) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult section of this Plan.

(10) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(11) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult section of this Plan.

(12) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(13) **Immunizations.** Immunizations are not eligible for individuals over the age of two (2), except as provided herein.

(14) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(15) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(16) **Marital counseling.** Charges for marital counseling.

PLAN EXCLUSIONS (cont'd)

(17) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(18) **No-fault.** Charges for which the Covered Person is entitled to benefits under any no-fault automobile or similar legislation.

(19) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(20) **Not approved.** Drugs and medicine not approved by the Federal Food and Drug Administration.

(21) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(22) **Nutritional supplements and vitamins.** Charges for nutritional supplements and vitamins.

(23) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary surgical charges for Morbid Obesity will be covered.

(24) **Occupational.** Charges in connection with an Illness or Injury for which the covered person is entitled to benefits under any Worker's Compensation or similar law; or for an Illness or Injury arising out of any employment for wage or profit, where such employment was not considered incidental employment or a source of incidental income. Incidental employment or incidental income are defined as a Covered Person's income producing activity which neither constitutes the type of work activity to which the Covered Person devotes the majority of their time nor which produces the majority of their gross income.

(25) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non hospital adjustable beds.

(26) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(27) **Pre-Existing Conditions.** For Pre-Existing Conditions as stated in this Plan.

(28) **Public Programs** to the extent that the Covered Person is reimbursed or entitled to reimbursement, or in any way indemnified for those expenses, to the extent to which this limitation is legally allowable.

(29) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(30) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(31) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(32) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(33) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(34) **War.** Any loss that is due to a declared or undeclared act of war.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Medical Cost Management for Medical and Surgical Precertification:
(800) 367-9938

American Health Care Partnership for Skilled Nursing Facilities:
(800) 550-2427

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least seven days in advance of services being rendered or within two days after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Skilled Nursing Facility stays

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

COST MANAGEMENT SERVICES (cont'd)

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least seven days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Participating Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within two days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $250.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

COST MANAGEMENT SERVICES (cont'd)

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- monitoring Hospital or Skilled Nursing Facility;
- assisting in obtaining any necessary equipment and services.
- contacting the family to offer assistance and support
- determining alternative care options; and

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PRESCRIPTION DRUG CARD BENEFITS

Participating Retail Pharmacies

Upon presentation of a valid Prescription Drug ID Card, an eligible Participant may obtain medications at Participating Pharmacies.

Participating Pharmacies will dispense prescriptions in a quantity not to exceed a thirty (30) day supply.

A Participant must meet an annual prescription drug deductible as indicated in the Schedule of Benefits. If a Participant has not met the deductible, he may be required to pay the entire cost of the prescription. After the deductible is met, the Participating Pharmacies shall charge and collect a copayment for each covered benefit according to the copayments outlined in the Schedule of Benefits.

Mail Service Pharmacy

An eligible Participant may obtain medications which are prescribed by a licensed Physician from the mail service pharmacy. If such prescription does not prohibit a Generic equivalent to be substituted, the mail service pharmacy will dispense such Generic equivalent to the eligible Participant.

Prescriptions will be dispensed from the mail service pharmacy in a quantity not to exceed a ninety (90) day supply. The mail service pharmacy shall charge Participants for prescriptions dispensed according to the copayments outlined in the Schedule of Benefits.

A Participant is not required to meet an annual deductible when using the Mail Service Pharmacy.

When Not Utilizing the Prescription Drug Card

If the expenses are not eligible under the terms of the Prescription Drug Card contract, but are otherwise eligible under the Plan, the provisions of Major Medical benefits and procedures apply.

If the expenses are eligible under the terms of the Prescription Drug Card contract and you do not use a Network Pharmacy, the expenses are ineligible for payment.

Prescription Drug Card – Covered Expenses:

(1) Federal Legend Prescription Drugs.

(2) Contraceptives, limited to: oral, injectables, implants and Depo-Provera.

(3) Estring.

(4) Insulin.

(5) Diabetic supplies.

(6) Injectables, limited to: Imitrex and bee sting kits.

(7) Prenatal vitamins.

(8) Vitamin A derivatives for dermatological treatment to age 23.

(9) Compounds that contain at least one Legend ingredient.

(10) Immunosuppressants.

PRESCRIPTION DRUG CARD BENEFITS (cont'd)

Prescription Drug Card – Expenses NOT Covered

(1) Drugs or medications obtainable without a prescription order from a licensed Physician, except insulin.

(2) Non-Legend drugs (OTC).

(3) OTC equivalents or Legend drugs that now are marketed by OTC.

(4) Anorexiants, appetite suppressants or other weight loss drugs, including Xenical.

(5) Dexedrine.

(6) Desoxyn.

(7) Fertility drugs.

(8) Injectables, unless otherwise indicated. Refer to Covered Charges under Medical Benefits.

(9) Immunologicals and vaccines, unless otherwise indicated.

(10) Cosmetic drugs or medications which include, but are not limited to: Retin A/Avita; Renova; Differin; Propecia tablets (hair loss); Vaniqua cream, except as otherwise indicated.

(11) Smoking cessation products.

(12) Vitamins and other Nutritional Supplements, except as otherwise noted.

(13) Erectile dysfunction drugs.

(14) Therapeutic devices or support garments and other non-medical substances.

(15) Respiratory therapy supplies, including Aerochamber and peak flow meters.

(16) Ostomy supplies.

(17) Non-insulin syringes and needles.

(18) Drugs intended for use in a Physician's office or another setting other than home use, unless otherwise indicated.

(19) Contraceptive devices.

(20) Human growth hormones.

(21) Fluoride preparations, including but not limited to tabs and drops.

(22) Vitamin A derivatives for dermatological/cosmetic treatment over age 23.

(23) Anti-narcolepsy/anti-hyperkinesis.

(24) Any items excluded in the Plan Exclusions section of the Plan.

(25) Any prescription filled in excess of the amount prescribed or in excess of the dispensing limitation.

(26) Any drug or medicine which is to be taken or administered while a person is confined in a Hospital or treatment facility.

PRESCRIPTION DRUG CARD BENEFITS (cont'd)

(27) Any drug labeled "Caution – limited by Federal Law to investigational use" or other wording having similar intent, or experimental drugs even though a charge is made to you or your Dependent.

(28) Prescription drugs and medicines not filled at an Express Scripts network pharmacy.

Note: Some expenses are not eligible under the terms of the Prescription Drug Card, but may otherwise be eligible under the Medical Plan. Please refer to Covered Charges under Medical Benefits.

DENTAL BENEFITS

If a Covered Person incurs expenses for covered dental services which were necessary and prescribed by a Dentist, he must submit proof of such expenses to the Plan Supervisor in the form of a properly completed claim form and itemized billing. The Plan will then pay the appropriate percentage of the reasonable and customary charges, up to the maximums stated in the Schedule of Benefits.

COVERED DENTAL SERVICES

Preventive Services

(1) Office visits for treatment and observation of injuries (other than routine operative procedures).

(2) Routine office visits for regular checkups (limited to one (1) per Calendar Year).

(3) Prophylaxis for individuals age fourteen (14) or over, treatment to include scaling or polishing (limited to one (1) treatment per Calendar Year).

(4) Topical application of sodium fluoride for Dependents under age fourteen (14) (limited to once per Calendar Year).

(5) Topical application of stannous fluoride for Dependents under age nineteen (19) (limited to once per Calendar Year).

(6) Fluoride supplement prescriptions for Dependent children, when prescribed by a Dentist.

Basic Services, including but not limited to:

(1) Office visits after hours.

(2) Consultation by a specialist for case presentation when diagnostic procedures have been performed by the general Dentist.

(3) Consultation for a second opinion for dental surgery only, second opinions for other dental services are not included.

(4) A second routine office visit for regular checkup during a Calendar Year (first covered under Preventive Services).

(5) A second prophylaxis for children under age fourteen (14) during a Calendar Year (first covered under Preventive Services).

(6) A second prophylaxis for individuals age fourteen (14) or over during a Calendar Year, treatment to include scaling or polishing (first covered under Preventive Services).

(7) Sealants applied to secondary (permanent) teeth for individuals under age nineteen (19) (limited to one (1) per tooth per three (3) years).

(8) Restorative services (amalgams/fillings).

(9) Gold restorations (when teeth cannot be restored with filling material).

(10) Crown restorations (when teeth cannot be restored with filling material).

(11) Simple extractions (non-impacted, non-orthodontic).

DENTAL BENEFITS (cont'd)

(12) Space maintainers including all adjustments within six (6) months of installation (limited to Dependents under age nineteen 19).

(13) Full and partial denture repairs.

(14) Adding teeth or partial denture to replace extracted natural teeth.

(15) Periodontics (treatment of diseases of the gums and other supporting tissue).

(16) Endodontics (treatment of pathological conditions within the pulp chamber or apical area of a tooth).

(17) Oral surgery (including extraction of impacted teeth).

(18) General and local anesthetic.

(19) Injection of antibiotic drug.

X-rays and Pathology

(1) Bitewing films, two (2) or four (4), including examination (limited to two (2) per Calendar Year).

(2) Intraoral single film and additional films up to thirteen (13) (limited to one complete series per three (3) years).

(3) Entire denture series consisting of at least fourteen (14) films, including bitewings if necessary (limited to one (1) per Calendar Year).

(4) Intraoral, occlusal view maxillary or mandibular.

(5) Superior or inferior maxillary extra-oral one (1) or two (2) films.

(6) Panoramic survey, maxillary and mandibular, single film (considered an entire denture series) (limited to one (1) every three (3) years).

(7) Biopsy and examination of oral tissue.

(8) Study models.

(9) Microscopic examination.

Major Services

(1) Prosthodontics, including, but not limited to, complete upper or lower denture ; adjustment, duplication, or relining or rebasing once per three (3) years; initial installation of bridges, pontics, retainers and crowns in relation to bridges.

(2) The Plan will not cover the replacement of bridges or dentures within five (5) years following the date of original insertion, nor the duplication of serviceable dentures.

Orthodontic Services

(1) Prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical means. Limited to Dependent children under age nineteen (19).